Washington State Department of Social & Health Services
MAA Medical Assistance Administration

ALIEN EMERGENCY MEDICAL PROGRAM
REFERRAL AND TRACKING

1. PATIENT/CLIENT NAME: LAST, FIRST	2. DATE OF BIRTH	3. DSHS CLIENT ID, if available or SOCIAL SECURITY NO.

4. The patient was treated, in the last 90 days, for the following emergent medical or dental condition(s):

- ☐ Amputation of limb – traumatic
- ☐ Appendicitis – Acute
- ☐ Asphyxia, (Strangling/Drowning)
- ☐ Asthma attack - Acute
- ☐ Bowel obstruction, infarction or perforation
- ☐ Cancer (requiring surgery, radiation, or chemotherapy)
- ☐ Cardiac arrest/Heart attack/Acute myocardial infarction
- ☐ Cerebral Vascular accident, stroke
- ☐ Coma
- ☐ Concussion
- ☐ Convulsion/Seizure
- ☐ Deep vein thrombosis
- ☐ Diabetic Keto-acidosis
- ☐ Dislocation of joint
- ☐ Ectopic pregnancy
- ☐ Electrocution
- ☐ Eye injury
- ☐ Fracture
- ☐ Gangrene
- ☐ HIV positive with complications/opportunistic infections
- ☐ Hypothermia
- ☐ Infection, cellulitis, or abscess
- ☐ Infectious Cholecystitis – Acute
- ☐ Insulin dependent diabetes mellitus
- ☐ Laceration of artery, nerve, or tendon
- ☐ Laceration or cut requiring sutures, staples or glue
- ☐ Liver Failure – Acute
- ☐ Malignant hypertension
- ☐ Meningitis; viral, bacterial or fungal
- ☐ Pancreatitis – Acute
- ☐ Poisoning due to food, drugs, or overdose
- ☐ Pneumothorax
- ☐ Post organ transplant care, including immunosuppressant (anti-rejection) medication. **Note: Organ transplants services are not covered under this program**
- ☐ Pylonephritis – Acute
- ☐ Renal failure – Acute or requiring dialysis
- ☐ Respiratory failure/breathing cessation
- ☐ Seizures
- ☐ Sunstroke/Heatstroke
- ☐ Traumatic brain injury
- ☐ Traumatic injury
- ☐ Tuberculosis
- ☐ Ulcer (Peptic or Gastric) with bleeding, perforation, and/or obstruction

5. If the patient was treated for a condition that is <u>not</u> indicated on the list above, please provide the diagnosis and chart notes. My diagnosis is: **Date of Treatment:** _____

6. NAME OF MEDICAL PROVIDER	7. TELEPHONE/FAX NUMBER

8. ADDRESS	CITY	STATE	ZIP CODE

9. SIGNATURE	DATE

For CSO and HRSA Use Only

CSO		CSO WORKER	
CSO MAILSTOP	TELEPHONE NUMBER	FAX NUMBER	DATE

MAA MEDICAL CONSULTANT SIGNATURE	DATE

MEDICAL ELIGIBILITY

☐ Denied, condition is not emergent ☐ Denied, Insufficient medical evidence ☐ Approved, for _____ months

ALIEN EMERGENCY MEDICAL PROGRAM	
ITEM	**INSTRUCTIONS**
1. Patient/Client Name	Must be last name, first name.
2. Date of Birth	Provide date of birth.
3. DSHS Client ID	Use the DSHS Client ID Number (if available) or their Social Security Number.
4. Emergent Medical or Dental Condition	Check all emergent medical or dental conditions the patient/client has been treated for **in the past 90 days.**
5. Diagnosis of Condition NOT Listed in Field 3	Provide the **diagnosis** and **chart notes** for any emergent condition NOT listed in Field 3.
6. Name of Medical Provider	Provide clearly legible name of medical provider.
7. Telephone/FAX Number	Provide a telephone or FAX number where the provider can be reached.
8. Address	Address of the provider including Street Address/PO Box, City, State and Zip Code.
9. Signature	Provider's Signature.